Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of	)	
	)	WC Docket No. 02-60
Rural Health Care Support Mechanism	)	

COMMENTS OF
THE UNIVERSITY OF ARKANSAS FOR MEDICAL SCIENCES

Respectfully submitted,

The University of Arkansas for
Medical Sciences

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TABLE OF CONTENTS

SUMMARY

The University of Arkansas for Medical Sciences ("UAMS") supports the Commission's proposal to establish a Health Infrastructure Program to address the continuing "large broadband connectivity gap" in the healthcare arena, particularly in rural areas. Regarding implementation of the Healthcare Infrastructure Program, UAMS supports the Commission's proposal to require applicants to provide at least a 15% match for proposed projects under the program. UAMS' experience has demonstrated that requiring applicants to demonstrate a match encourages fiscally responsible planning. In addition, UAMS supports the Commission's proposal to require applicants to submit letters of assurances confirming eligible source funding within 90 days of application selection. Finally, UAMS does not support the Commission's proposal to exclude "in-kind" contributions from the list of eligible matching sources. Consistent with the BTOP program, eligible matching sources should include "in-kind" sources, as many prospective healthcare applicants, rural and urban, do not have the resources to provide a cash match. Many of the healthcare entities the Commission proposes to serve through will be limited in their ability to participate in the program unless they are permitted to receive in-kind contributions. UAMS' experience has demonstrated that short-term leases promote increased competition and progressively lower prices each year they are bid out. As such, UAMS supports shorter term leases. In addition, in order to better understand what rules are applicable to "long-term" and "short-term" leases in the Healthcare Infrastructure Program and to ensure regulatory certainty, the Commission should propose explicit definitions of both terms for public comment before deciding to exclude any leases from eligibility. In addition, UAMS recommends a sustainability plan period of eight years – rather than ten – which is a length consistent with the Broadband Technology Opportunities Program. Further, UAMS supports a Commission policy that encourages and permits joint projects that include additional capacity for use by the community (i.e., not for healthcare purposes). Based on UAMS' positive experience in this area, the Commission should indeed encourage all the listed groups to be eligible for community use of excess capacity funded by the Healthcare Infrastructure Program. Similarly, the Commission should grant a priority preference for Healthcare Infrastructure Program programs that include additional capacity for community use. Such a standard would ensure that the historical "silo" approach to broadband expansion is finally terminated.

UAMS also supports the Commission's proposal to replace the existing internet access program with a new Health Broadband Services Program which will subsidize 50% of an eligible rural healthcare provider's recurring monthly costs for point-to-point advanced telecommunications and information services. As to the rules which will govern the program, UAMS notes that imposing a minimum bandwidth capability for healthcare providers under the Health Broadband Services Program may, as an unintended consequence, limit the ability of the most deserving providers to obtain the benefits of the program. Therefore, UAMS supports a low threshold for program eligibility: 1.5 Mbps. In addition, UAMS suggests one-time support equal to 85% of reasonable and customary installation charges for broadband access, a suggestion in accordance with the FCC Rural Health Care Pilot Program. Further, UAMS supports the

Commission's proposal to allow the use of evergreen contracts under the health broadband services program, as an annual reapplication requirement creates a barrier to broadband expansion for smaller healthcare entities with little to no expendable administrative budget and becomes cumbersome to larger entities with widespread projects.

UAMS proposes several entities that may not yet have been considered in the identification of eligible healthcare providers. As such, although these entities do not clearly fall within the proposed eligible categories presented by the Commission, UAMS sees merit in including the following types of entities within the Commission proposed programming: Public and Private Schools' Nurse Offices, Correctional Facilities' Nurse Offices; and Human Development Centers.

As to the Commission's proposals regarding data gathering and performance measures, UAMS submits that while HHS's "meaningful use" criteria is a necessary and appropriate tool for determining levels of usage with respect to electronic health records, such a term does not directly address or help quantify the total number of connected and covered sites in a system funded under the Rural Health Care Support Mechanism, nor does the "meaningful use" criteria reflect the increase in a covered site's overall broadband capabilities with respect to telehealth. Such measurements (connected sites/increased broadband capabilities) should be the yardsticks against which performance should be measured in the Rural Health Care Support Mechanism, particularly because the newly minted "meaningful use" concept is undoubtedly going to evolve over time. In addition, UAMS submits that performance reports should be collected annually so that progress can be batched into meaningfully sized units. Finally, UAMS supports the idea of creating a working group to help develop recommendations for the direction of the Rural Health Care Support Mechanism. Such a group should ideally include healthcare providers who participate within the Healthcare Infrastructure Program and the Health Broadband Services Program. Additionally, UAMS suggests that representatives from National LambdaRail and Internet2 consortiums be included in such working group.

Regarding subsection (c)(4) of proposed Section 54.603, requiring healthcare administrators to provide paper copies of responses or bids, UAMS strongly recommends that electronic copies of all paper documents suffice due to the cumbersome and wasteful nature of requiring paper copies of bids or responses to calls for bids. Regarding Section 54.655, training for usage of telemedicine applications should be an eligible cost, as such training is imperative to successful adoption of the technology.

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The University of Arkansas for Medical Sciences ("UAMS"), by undersigned counsel, hereby submits these comments to the Federal Communications Commission ("Commission") pursuant to a Notice of Proposed Rulemaking[1] relating to the agency's solicitation for comments on reforms to the universal healthcare support mechanism consistent with the recommendations set forth by the National Broadband Plan.

I. UAMS' Interest in this Proceeding

UAMS not only serves as Arkansas's only academic medical center, but the University also is a leader in the state for providing assistance to rural healthcare facilities in acquiring and sustaining broadband speeds capable of facilitating participation in telemedicine and other broadband health applications. In 2007, UAMS was approved for a $4 Million FCC Rural Health Care Pilot Program ("Pilot Program") award, which seeks to install 1.5 Mbps broadband lines at over 300 healthcare facilities in Arkansas. Since that time, UAMS has partnered with over 400 healthcare facilities in Arkansas to specifically connect their facilities to a statewide broadband network aimed at increasing access to specialty healthcare and distance education in rural areas. In 2010, UAMS was

[1] In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60, FCC 10-125 (July 15, 2010) ("Notice").

awarded a Broadband Technology Opportunities Program ("BTOP") Comprehensive Community Infrastructure award that supports a $128 Million project to extend upgraded broadband and interactive video equipment to 474 healthcare, higher education, public safety, and research institutions in Arkansas. As such, UAMS has extensive experience in building health infrastructure that specifically meets the needs of rural facilities in Arkansas, a state where every county contains medically underserved or healthcare provider shortage areas.

II. Healthcare Infrastructure Program

UAMS supports the Commission's proposal to establish a Health Infrastructure Program to address the continuing "large broadband connectivity gap" in the healthcare arena, particularly in rural areas.[2] While the Pilot Program and BTOP have provided much needed initial momentum to address connectivity for healthcare anchor institutions, in rural areas there remains a significant dearth of resources necessary to complete this critical project. The Health Infrastructure Program can help close the loop with respect to rural broadband connectivity in the healthcare context, and therefore the Commission's proposal to establish this program should be adopted. With respect to the Commission's specific proposals in the Notice regarding implementation of the Healthcare Infrastructure Program, UAMS' comments are set forth below, with reference to the paragraphs in the Notice containing those proposals.

A. Paragraphs 44-47 (Matching Funds/Eligible Contribution Sources)

UAMS supports the Commission's proposal to require Healthcare Infrastructure Program applicants to provide at least a 15% match for proposed projects under the program. UAMS' experience has demonstrated that requiring applicants to demonstrate a

[2] Notice at ¶12.

match encourages fiscally responsible planning. Given the finite resources available for this program, such accountability is necessary.

Prompt implementation of a selected Healthcare Infrastructure Program project is appropriate, given the importance of healthcare connectivity as confirmed in the National Broadband Plan. Thus, UAMS supports the Commission's proposal to require applicants to submit letters of assurances confirming eligible source funding within 90 days of application selection.

Finally, UAMS does not support the Commission's proposal to exclude "in-kind" contributions from the list of eligible matching sources. Consistent with the BTOP program, eligible matching sources should include "in-kind" sources, as many prospective healthcare applicants, rural and urban, do not have the resources to provide a cash match. The BTOP Program, for example, permitted in-kind expenses that included: (i) state or other non-federal grant awarded to provide broadband services, purchase equipment, and provide training; (ii) previously used equipment; (iii) unpaid volunteer services; (iv) loan proceeds; and (v) federal funds (whether from a grant, loan, or other source) expressly authorized by statute for use as matching funds.[3] For BTOP, UAMS as well as many other BTOP grantees received significant in-kind match contributions from BTOP project partners, including a wide range of rural, urban, large, and small community facilities. Of the 20% required BTOP match provided on the approved UAMS proposal, only 3% comprises a cash match, with in-kind sources comprising the remaining 17%. Many of the healthcare entities the Commission proposes to serve

[3] See "Round 2 Grant Guidance Comprehensive Community Infrastructure", Broadband Technology Opportunities Program, U.S. Department of Commerce, National Telecommunications and Information Administration, Version 1, Page 6 (February 11, 2010)

through the Health Infrastructure Services Program will have substantially limited resources and capacity to self-fund the required match, and therefore will be limited in their ability to participate in the program unless they are permitted to receive in-kind contributions. Yet these same providers - *those who cannot afford broadband connection, let alone 15% cash match* - are those entities most in need of the Health Infrastructure Program. Given the strong policy reasons underlying the National Broadband Plan to ensure widespread deployment of broadband to healthcare entities, and the absence of any countervailing policy reason, the Commission should permit in-kind contributions to be used towards satisfaction of the matching requirement.

B. Paragraph 58 (Short-Term Leases)

UAMS' experience has demonstrated that short-term leases promote increased competition and progressively lower prices each year they are bid out. In each bidding cycle, more vendors materialize to bid and become increasingly willing to offer more advantageous terms and pricing in an attempt to acquire business. As such, UAMS supports shorter term leases, which provide opportunities for progressively efficient and cost-effective services in subsequent years for those healthcare entities who struggle to secure affordable broadband rates. A decision to ban short-term leases from the Healthcare Infrastructure Program would destroy a mechanism that has proven beneficial to UAMS and the 400+ rural healthcare facilities the University assists in acquiring and sustaining affordable broadband.

In addition, in order to better understand what rules are applicable to "long-term" and "short-term" leases in the Healthcare Infrastructure Program and to ensure regulatory

certainty, the Commission should propose explicit definitions of both terms for public comment before deciding to exclude any leases from eligibility.

C. Paragraph 65 (Sustainability Plans)

A ten-year sustainability plan is lengthy compared to other federal programs, such as the Broadband Technology Opportunities Program. UAMS recommends a sustainability plan period of eight years, a length consistent with the Broadband Technology Opportunities Program.

D. Paragraph 78 (Eligibility for Community Use Additional Capacity)

UAMS supports a Commission policy that encourages and permits joint projects that include additional capacity for use by the community (i.e., not for healthcare purposes). In UAMS' experience, broadband infrastructure projects characterized by diversity and inclusiveness among community anchor institutions, and public/private partnerships, serve only to strengthen such projects, allowing funding to reach more disenfranchised populations, such as the significantly underserved populations in Arkansas. UAMS' funded infrastructure projects have involved participation from most of the groups specified by the Commission. Based on this positive experience, the Commission should indeed encourage all the listed groups to be eligible for community use of excess capacity funded by the Healthcare Infrastructure Program.

E. Paragraph 79 (Priority Preferences for Projects with Additional Capacity for Community Use)

Community partnership with healthcare resources and facilities is of paramount importance to successful health care. Infrastructure projects that leverage the benefits and expertise of varied community anchor institutions such as healthcare providers, schools and libraries, state and local governments, and others offer a greater opportunity

for ensuring broadband access to the greatest number of people. In that regard, Congress, in passing the American Recovery and Reinvestment Act ("ARRA") and BTOP, required consideration of whether "an application to deploy infrastructure will … enhance services for health care delivery, education or children to the greatest population of users in the area."[4] Indeed, one of the express purposes of BTOP is to provide "broadband education, awareness, training, access, equipment and support to …[s]chools (including institutions of higher education), libraries, medical and health care providers, and other community support organizations to promote greater use of broadband by and through these organizations."[5] Such policy priorities should continue to be encouraged, in this instance through the Commission's granting of a priority preference for Healthcare Infrastructure Program programs that include additional capacity for community use. Such a standard would ensure that the historical "silo" approach to broadband expansion is finally terminated.

III. Health Broadband Services Program

UAMS supports the Commission's proposal to replace the existing internet access program with a new Health Broadband Services Program which will subsidize 50% of an eligible rural healthcare provider's recurring monthly costs for point-to-point advanced telecommunications and information services.

The affordability of broadband at rural healthcare facilities is substantially limited in Arkansas. Through the use of focus groups, statewide consortiums, and numerous statewide surveys, UAMS has been able to identify the limitations, needs, and current capacities of health-related broadband in Arkansas. Therefore, the following comments

[4] Pub. L. 111-5, 123 Stat. 115 (2009), BTOP, §6001(h)(2)(C).
[5] BTOP, §6001(b)(3)(A).

reflect issues faced by over 400 healthcare providers in Arkansas, as well as lessons learned from UAMS' interactions with rural healthcare providers throughout the state.

A. Paragraph 97 (Minimum Broadband Capabilities)

Imposing a minimum bandwidth capability for healthcare providers under the Health Broadband Services Program may, as an unintended consequence, limit the ability of the most deserving providers to obtain the benefits of the program. Therefore, UAMS supports a low threshold for program eligibility: 1.5 Mbps.

While UAMS recognizes the need for significant bandwidth at some of its larger partnering sites, a vast majority of such partnering sites do not require and cannot support bandwidth exceeding certain levels. For example, even the state's only public health department has requested 1.5 Mbps for its sites, stating that this level of bandwidth will accommodate patient volume and funding would be available to sustain the recurring line charge; whereas, a higher bandwidth would produce recurring charges outside of their financial capabilities. With respect to these sites, a 10-Mbps limit would place these 100+ facilities in a situation where they are forced to pay for much more bandwidth than they need. In essence, some rural healthcare facilities are simply not ready for bandwidth of the suggested size from a usage standpoint, and further, even with a 50% discount, affording the costs for that broadband speed would in many cases be impossible.

As a dramatic illustration of the financial limitations of healthcare facilities in Arkansas and the inability of the state's hospitals to afford new recurring expenses, the Arkansas Hospital Association 2008 Annual Report found that Arkansas's hospitals only cleared 26 cents a day in 2007 (a statistic which predated the recent economic

downturn).[6] Arkansas's hospitals exemplify the needs typical of all the healthcare providers serving rural Arkansas. Thus, while a program like the Health Broadband Services Program promises to greatly assist these facilities to secure and sustain broadband, placing a minimum bandwidth on these facilities could impose a monthly recurring charge that is difficult to maintain even with 50% federal assistance.

In summary, bringing health broadband to rural areas like Arkansas is essential, but this may be a process that requires lower bandwidth requirements and more consideration for the tight budgets and lower patient volumes that rural facilities encounter. For these reasons, UAMS supports a 1.5 Mbps minimum level of broadband capability. Placing further restrictions on bandwidth could preclude participation from some facilities that need the assistance the most.

B. Paragraph 100 (One-Time 50% Support for Broadband Installation)

For the reasons described above, Arkansas's healthcare facilities' financial climate is not conducive to supporting broadband access, especially in rural areas, without federal funding help. Thus, UAMS suggests one-time support equal to 85% of reasonable and customary installation charges for broadband access, a suggestion in accordance with the FCC Rural Health Care Pilot Program.

C. Paragraph 112 (Contract Length and Reapplication)

UAMS supports the Commission's proposal to allow the use of evergreen contracts under the health broadband services program, as an annual reapplication

[6] Specifically, the report found that (i) Arkansas's regional hospitals charged $12.8 billion for inpatient and outpatient care provided at their facilities in 2007; (ii) Due to the lack of full reimbursement from all payer groups, revenue failed to cover expenses by $824,679; (iii) Thus, hospitals earned $0.26 on each of the equivalent days of care they provided to inpatients and outpatients. The resulting "patient service" margin yields -0.02%.

requirement creates a barrier to broadband expansion for smaller healthcare entities with little to no expendable administrative budget and becomes cumbersome to larger entities with widespread projects.

IV. Eligible Health Care Providers

Paragraph 115: Eligible Health Care Providers

UAMS proposes several entities that may not have been considered in the identification of eligible healthcare providers. As such, although these entities do not clearly fall within the proposed eligible categories presented by the Commission, UAMS sees merit in including the following types of entities within the Commission proposed programming:

- *Public and Private Schools' Nurse Offices*: Schools offer healthcare pediatric services that are unique in the way they reach every school-age child, regardless of their income, accessibility to a primary care provider, or other barriers such as the ability for their parent to take time off work to take their child to a doctor's appointment, available transportation to a doctor's office, etc. UAMS has partnered with school nurse offices to offer telemedical care through broadband, yet the availability and affordability of dedicated broadband lines to support telemedicine exchange has created a distinct disadvantage in building these virtual clinics. By including public- and private-school nurse offices as eligible healthcare providers, more children could receive telemedicine-based pediatric support without ever leaving their school, a practice that has

demonstrated decreased absenteeism and improved grades amongst UAMS' school-based telehealth programs.

- *Correctional Facilities' Nurse Offices*: Prisons and correctional facilities also provide fertile ground for telemedicine activity between healthcare providers and the nurse office serving inmates, many of whom face high-risk conditions and need medical support while incarcerated. UAMS' telemedicine experience with correctional facilities has demonstrated decreased inmate transportations to healthcare facilities, which has significantly reduced costs to the state prison system. With appropriate levels of broadband, these nurse offices can offer cost-saving medical support to prisoners, a population in need of any range of services from mental health counseling to high-risk obstetrics.
- *Human Development Centers*: Human Development Centers offer healthcare providers the forum to reach adults with developmental disabilities and behavioral disorders for telemedicine-based rehabilitation and other medical services. These centers are gathering places for individuals who can benefit from counseling and services that can help them live independent lives. By including Human Development Centers as eligible healthcare providers, these facilities can acquire dedicated broadband levels that can support telemedicine activities.

V. Data Gathering and Performance Measures

A. Paragraph 144 (Requiring Compliance with Meaningful Use)

While HHS's "meaningful use" criteria is a necessary and appropriate tool for determining levels of usage with respect to electronic health records, such a term does not directly address or help quantify the total number of connected and covered sites in a system funded under the Rural Health Care Support Mechanism, nor does the "meaningful use" criteria reflect the increase in a covered site's overall broadband capabilities with respect to telehealth. Such measurements (connected sites/increased broadband capabilities) should be the yardsticks against which performance should be measured in the Rural Health Care Support Mechanism, particularly because the newly minted "meaningful use" concept is undoubtedly going to evolve over time.

B. Paragraph 147 (Frequency of Performance Assessments)

UAMS submits that performance reports should be collected annually so that progress can be batched into meaningfully sized units. Due to the fact that the Healthcare Infrastructure Program and Health Broadband Services Program will be new programs and will likely continue to need adjustments based on lessons learned, performance standards should provide data needed to reform the program and allow further programmatic revisions of such performance measures. Until performance measures are solidified, ongoing support must be conditioned only on those standards proven to have validity over the initial years of the grant.

C. Paragraph 150 (Working Group)

UAMS supports the idea of creating a working group to help develop recommendations for the direction of the Rural Health Care Support Mechanism. Such a

group should ideally include healthcare providers who participate within the Healthcare Infrastructure Program and the Health Broadband Services Program. Additionally, UAMS suggests that representatives from National LambdaRail and Internet2 consortiums be included in such working group.

VI. Appendix A – Proposed Rules

A. Section 54.603

With respect to subsection (c)(4), requiring healthcare administrators to provide paper copies of responses or bids, UAMS strongly recommends that electronic copies of all paper documents suffice due to the cumbersome and wasteful nature of requiring paper copies of bids or responses to calls for bids.

B. Section 54.655

Training for usage of telemedicine applications should be an eligible cost, as such training is imperative to successful adoption of the technology. In UAMS' experience, healthcare entities who do not have the proper training for their staff are less likely to participate in activities that employ advanced technologies, such as telemedicine, teleconferencing, and other emerging health information technologies. In some cases, telemedicine units were locked, hidden in closets at hospitals whose staffs never received training on the use of equipment nor direction on how to connect to remote sites through broadband. Through a contract with the state, UAMS actively provided training to these sites, which now function fully in telemedicine and distance education, employing the very telemedicine units and broadband connections that were available, yet avoided and forgotten, prior to training. With this experience and many others strikingly similar,

UAMS advocates for technology training to be an eligible expense covered by the proposed Commission programs.

VII. Conclusion

For the foregoing reasons, UAMS respectfully requests that the Commission adopt rules consistent with the above comments.

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